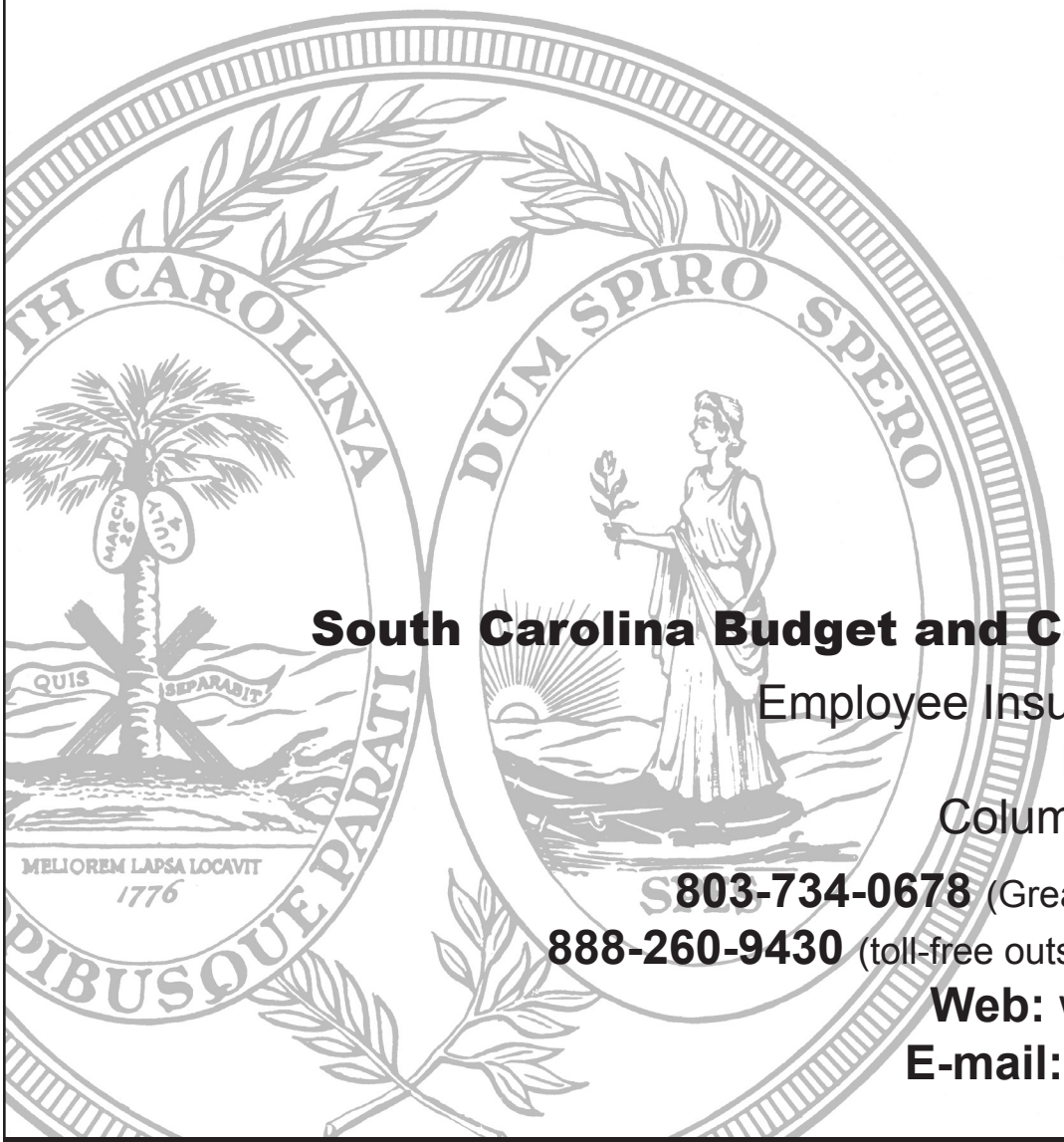
2008

When You Become Eligible for Medicare Handbook



South Carolina Budget and Control Board

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Introduction

This book is designed to provide you information that will help you make insurance coverage decisions when you become eligible for Medicare. Please review this book and discuss your benefit choices with dependent family members before making decisions. More detailed information regarding the benefits programs may be found in the *Insurance Benefits Guide*, which is available from your employer or from the Employee Insurance Program (EIP). Please contact EIP if you have any questions or need additional information. You may visit our Web site at www.eip.sc.gov or call us at 803-734-0678 (Greater Columbia area) or 888-260-9430 (toll-free outside the Columbia area).

BENEFITS ADMINISTRATORS AND OTHERS CHOSEN BY YOUR EMPLOYER WHO MAY ASSIST WITH INSURANCE ENROLLMENT AND ADJUSTMENTS, RETIREMENT OR TERMINATION AND RELATED ACTIVITIES ARE NOT AGENTS OF THE EMPLOYEE INSURANCE PROGRAM AND ARE NOT AUTHORIZED TO BIND THE EMPLOYEE INSURANCE PROGRAM.

THIS BOOKLET CONTAINS AN ABBREVIATED DESCRIPTION OF INSURANCE BENEFITS. THE *PLAN OF BENEFITS* DOCUMENTS AND BENEFITS CONTRACTS CONTAIN COMPLETE DESCRIPTIONS OF THE HEALTH AND DENTAL PLANS AND ALL OTHER INSURANCE BENEFITS. THEIR TERMS AND CONDITIONS GOVERN ALL BENEFITS OFFERED BY THE STATE. IF YOU WOULD LIKE TO REVIEW THESE DOCUMENTS, CONTACT YOUR BENEFITS ADMINISTRATOR OR THE EMPLOYEE INSURANCE PROGRAM.

THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE AN EMPLOYMENT CONTRACT BETWEEN THE EMPLOYEE AND THE AGENCY. THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS. THE AGENCY RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT, IN WHOLE OR IN PART. NO PROMISES OR ASSURANCES, WHETHER WRITTEN OR ORAL, WHICH ARE CONTRARY TO OR INCONSISTENT WITH THE TERMS OF THIS PARAGRAPH CREATE ANY CONTRACT OF EMPLOYMENT.

When You or Your Dependents Become Eligible for Medicare

About Medicare

Medicare includes *Part A*, *Part B and Part D*. To find out more:

- Read *Medicare & You 2008.*
- Visit the Medicare Web site at www.medicare.gov.
- Call Medicare at 800-633-4227 or 877-486-2048 (TTY).

Medicare Part A

Part A is your hospital insurance. Most people do not pay a premium for Part A because they or their spouse paid Medicare taxes while they were working. Part A helps cover your inpatient care in hospitals, in critical access hospitals in rural areas and in skilled nursing facilities. Part A has an inpatient hospital deductible for each benefit period. For 2008, it is $1,024. Part A also covers hospice care and some home healthcare. You must meet certain requirements to be eligible for Part A. Contact Medicare for additional information.

IMPORTANT MEDICARE NOTE

If you or one of your dependents become eligible for Medicare due to age or disability, you must notify EIP within 31 days of eligibility. If you do not notify EIP of your Medicare eligibility, and EIP continues to pay benefits as if it were your primary insurance, when EIP discovers you are eligible for Medicare, EIP will:

- **Begin paying benefits as if you were enrolled in Medicare**
- **Seek reimbursement for overpaid claims back to the date you or your dependent(s) became eligible for Medicare.**

Medicare Part B

Part B is your medical insurance. Most people do pay a premium through the Social Security Administration for Part B. It helps cover doctors' services and outpatient hospital care. It also covers some medical services that Part A does not cover, such as some of the services of physical and occupational therapists and home healthcare. Part B pays for these covered services and supplies when they are medically necessary. In 2008, the Part B deductible is $135 a year.

When you become eligible for Medicare, it is important to be enrolled in Part B if you are covered as a retiree or as a dependent of a retiree. Medicare becomes your primary insurance, and your retiree group insurance becomes the secondary payer. If you are not enrolled in Part B, you will be required to pay the portion of your healthcare costs that Part B would have paid.

Medicare Part D

Part D, the prescription drug plan, became effective January 1, 2006. However, most subscribers covered by the Standard Plan, the Medicare Supplemental Plan or the health maintenance organizations offered through the Employee Insurance Program (EIP) should not sign up for Medicare Part D.

The prescription drug benefit provided through your health plan is as good as, or better than, Part D for most people. Because you have this coverage, your drug expenses will continue to be reimbursed through your health insurance. Before you turn 65 and become eligible for Medicare, you will receive a Notice of Creditable Coverage letter from EIP officially notifying you that you do not need to sign up for Part D. There is a copy of the letter on pages 27-29. (If you become eligible for Medicare before age 65, the letter will not be sent to you.)

If you or your eligible dependent enrolls in Medicare Part D, you, or he, will lose the prescription drug coverage provided by your health plan with EIP. However, the premium for your health plan will not be reduced.

You may have heard that if you do not sign up for Part D when you are first eligible — then later do so — you will have to pay higher premiums for Part D. For EIP subscribers, this is not true. According to Medicare rules, Medicare recipients who have "creditable coverage" (drug coverage that is as good as, or better than, Part D) and who later decide to sign up for Part D, will not be penalized by higher Part D premiums. Subscribers to the health plans offered through EIP have creditable coverage. However, please save your Notice of Creditable Coverage letter from EIP in case you need to prove you had this coverage when you became eligible for Part D.

Most people should not respond to information they may get from Medicare or advertisements from companies asking them to buy Part D prescription drug plans.

The federal government does offer extra help in paying for Medicare Part D, but not EIP drug coverage, for people with limited income and resources. If you think you may qualify for this assistance, go to the Social Security Administration's Web site at www.socialsecurity.gov or call 800-772-1213 or 800-325-0778 (TTY).

Please remember: Medicare Part D does not affect your need to enroll in Medicare Part B (medical insurance). As a retiree covered under EIP's insurance, you must enroll in Part A and Part B when you become eligible for Medicare due to a disability or due to age. If you are not enrolled in both parts of Medicare, you will be required to pay the portion of your healthcare costs that Medicare would have paid.

Medicare Before Age 65: Disability Retirees

If you or your spouse becomes eligible for Medicare before age 65 due to disability, including end-stage renal disease (ESRD), you must notify EIP within 31 days of Medicare eligibility. When you notify EIP, please submit a copy of your Medicare card.

Because Medicare is primary (pays first) over your retiree health insurance plan, when you become eligible for Medicare, you must enroll in Medicare Part A and Part B. If you are not enrolled in Part B, you will be required to pay the portion of your healthcare costs that Part B would have paid. EIP will not pay these costs.

If you do not enroll in Medicare Part B when you are first eligible, you must wait until Medicare's General Enrollment Period. This period is from January 1 to March 31 of each year, and coverage begins on July 1. Your Medicare premium will be 10 percent higher for each year you did not enroll in Part B after you were first eligible. Contact Medicare for enrollment details and for premium information that applies specifically to you.

IF YOU HAVE END-STAGE RENAL DISEASE

You will become eligible for Medicare three months after beginning dialysis. At this point, a 30-month "coordination period" begins. During this period, your health coverage through EIP is primary, which means it pays your medical claims first. After 30 months, Medicare becomes your primary coverage. Please notify EIP within 31 days of the end of the coordination period. At that time, you will have the option of changing to the Medicare Supplemental Plan. (The Medicare Supplemental Plan is not available to active employees or their covered dependents.)

The coordination period applies whether you are an active employee, a retiree, a survivor or a covered dependent and whether you were already eligible for Medicare for another reason, such as your age. If you were covered by the Medicare Supplemental Plan, you will be switched the Standard Plan for the 30 months of the coordination period.

If you wish to switch to the Medicare Supplemental Plan, you must complete a Notice of Election form within 31 days of Medicare eligibility. You will not be automatically enrolled in the plan.

Medicare At 65 if You Are Retired

At age 65, Medicare is primary (pays first) over your retiree health insurance plan. You must enroll in Medicare Part A and Part B. If you do not enroll in Medicare A and B, you will be required to pay the portion of your healthcare costs that Medicare would have paid.

Medicare's Initial Enrollment Period starts three months before the month you turn age 65 and extends three months past the month you turn 65. If you are not receiving Social Security benefits, you should inquire about filing for Medicare three months before you turn age 65 so your Medicare coverage can start the month you turn 65.

If you are receiving Social Security benefits, you should be notified of Medicare eligibility by the Social Security Administration three months before you reach age 65. Medicare Part A starts automatically, and you must enroll in Part B. If you are not notified, contact your local Social Security office immediately.

If you decide to delay receiving your Social Security benefits until you reach **your** full Social Security retirement age, you must still apply for Medicare A and B benefits. We recommend you contact the Social Security Administration within three months of your 65th birthday to enroll. The Social Security Administration will bill you quarterly for the premium for Medicare Part B.

When you enroll in Medicare, you should notify EIP and send in a copy of your Medicare card.

If You Are an Active Employee at Age 65

If you are actively working and/or covered under a state health plan for active employees, you may defer enrollment in Part B because your insurance as an active employee remains primary while you are actively working.

If you are an active employee but your spouse is eligible for Medicare, your spouse should enroll in Part A but may delay enrollment in Part B until you retire and your active coverage ends.

Social Security has a special enrollment rule for employees ending active employment after age 65. You should contact the Social Security Administration within 90 days of your retirement date to ensure that your Medicare A and B coverage begins on the same date as your retiree coverage.

Remember: When you retire you must sign up for Part A and Part B within 31 days of retirement because Medicare becomes your primary coverage.

Sign up for Parts A and B of Medicare

You must enroll in both Part A and Part B of Medicare to receive full benefits with any state-offered retiree group health plan. If you are not enrolled in both parts of Medicare, you will be required to pay the portion of your healthcare costs that Medicare Part B would have paid.

HOW MEDICARE PAYS ITS SHARE OF THE COST OF YOUR CARE

Under Medicare assignment, the Medicare subscriber agrees to have Medicare's share of the cost of services paid directly ("assigned") to a provider. Participating providers have agreed to submit all of their Medicare claims on an assigned basis. Non-participating providers may choose whether

to accept assignment on each individual claim. If you receive services from a non-participating physician, ask if he will accept assignment.

When you become eligible for Medicare due to age or disability, you MUST notify EIP within 31 days.

Each year, doctors and suppliers have the opportunity to participate in Medicare. After you meet your deductible and pay your co-insurance, if it applies, doctors and suppliers participating in the program will accept the Medicare-approved amount as payment in full. If a doctor does not accept assignment, you may pay more for his services.

If a doctor decides to participate, he cannot drop out in the middle of the year. Independent laboratories and doctors who perform diagnostic laboratory services and non-physician practitioners must accept assignment.

Your Health Options With Medicare

When you and/or your eligible dependents are covered under retiree group health insurance and become eligible for Medicare, Medicare becomes the primary payer, and your health options change. Before you turn 65, EIP will send you a letter offering you and your eligible dependents a choice of the Standard Plan, the Medicare Supplemental Plan, CIGNA Healthcare HMO, BlueChoice HealthPlan or MUSC Options. (To enroll in an HMO, it must be offered in the county in which you live.)

If you become eligible for Medicare due to age, and you are covered by the Standard Plan or the Savings Plan, you will be automatically enrolled in the Medicare Supplemental Plan unless you respond to the letter by choosing another plan. Coverage changes must be made within 31 days of the date you become eligible for Medicare.

Would you like more information about your health insurance choices when you become eligible for Medicare? See pages 20-23 for comparison tables.

If you are enrolled in the Medicare Supplemental Plan, the claims of your eligible dependent(s) without Medicare are paid through the Standard Plan's provisions.

The Savings Plan is not available to you if you are retired and eligible for Medicare.

The Standard Plan

The State Health Plan Standard Plan offers worldwide coverage. It requires Medi-Call approval for inpatient hospital admissions; all maternity benefits (you must call in the first trimester); outpatient surgical services in a hospital or clinic; the purchase or rental of durable medical equipment; and skilled nursing care, hospice care and home healthcare. **You must also call APS Healthcare, Inc., the SHP's behavioral health manager, for preauthorization before you receive mental health or substance abuse care.**

The plan has both deductibles and coinsurance. Once you become eligible for Medicare, Medicare becomes your primary insurance coverage. The Standard Plan uses a carve-out method, which is described on page 9, to pay your claims.

HOW THE STANDARD PLAN AND MEDICARE WORK TOGETHER

Using Medi-Call as a Retiree

Medicare has its own program for reviewing use of its benefits. However, you still need to call Medi-Call when Medicare benefits are exhausted for inpatient hospital services (including hospital admissions outside South Carolina or the U.S.), and for extended care services, such as skilled nursing facilities, private duty nursing, home healthcare, durable medical equipment and Veterans Administration hospital services.

Note: Any covered family members who are not eligible for Medicare and have their claims processed under the Standard Plan must call Medi-Call.

Please remember that while your physician or hospital may call Medi-Call for you, it is your responsibility to see that the call is made.

Hospital Network

When you are eligible for Medicare, Medicare is the primary payer, and you may go to any hospital you choose. Medicare limits the number of days it will cover for hospital stays. If you are enrolled in the Standard Plan and your hospital stay exceeds the number of days allowed under Medicare, it may be important to you that you are admitted to a hospital within the State Health Plan network or BlueCard Program so that you will not be charged more than what the Standard Plan allows. *Note: Mental health and substance abuse services are covered only at APS Healthcare, Inc., network facilities.*

You must also call Medi-Call for approval of any additional inpatient hospital days beyond the number of days approved under Medicare and for services related to home healthcare, hospice, durable medical equipment and Veterans Administration hospital services.

Private Duty Nursing if You Have Medicare

Medicare does not cover private duty nursing. However, the Standard Plan does cover medically necessary, intermittent private duty nursing services. The regular coinsurance rate and the deductible, if you have not satisfied it, apply for approved charges. Remember to call Medi-Call for private duty nursing services.

When Traveling Outside South Carolina

You are not generally covered outside the United States under Medicare. However, if you are enrolled in the Standard Plan, you have worldwide access to doctors and hospitals through the BlueCard program. If you are admitted to a hospital outside the state or the country as a result of an emergency, notify Medi-Call and follow the BlueCard guidelines.

Mental Health and Substance Abuse: Using APS as a Retiree

If you are eligible for Medicare and covered under the Standard Plan, you must call APS Healthcare, Inc., the SHP's behavioral health manager, at 800-221-8699 for approval of inpatient hospital stays. Preauthorization and continued-stay authorizations by APS are required for inpatient care, including care in a Veterans Administration hospital. If your Medicare benefits are exhausted, you must call APS to receive authorization for continued benefits under the Standard Plan. To receive benefits, you must use an APS network provider.

Note: Any covered family members who are not eligible for Medicare and have their claims processed under the Standard Plan must also call to register with APS and use an APS network provider.

Prescription Drug Program

The Standard Plan covers prescription drugs when purchased from a participating pharmacy. Please refer to page 54 of your 2008 *Insurance Benefits Guide* for more information on the State Health Plan Prescription Drug Program.

Ambulatory Surgical Center Network

These facilities provide some of the same services offered in the outpatient department of a hospital. If you are enrolled in Medicare, there is no need to call Medi-Call for preauthorization, nor do you need to select a center that participates in the network.

Transplant Contracting Arrangements

As part of this network, you have access to the leading transplant facilities in South Carolina and throughout the nation. If you are enrolled in Medicare, there is no need to call Medi-Call for preauthorization, nor do you need to select a facility that participates in the network.

Mammography Testing Benefit

The State Health Plan pays for routine mammograms for covered women ages 35-74. You may have one baseline mammogram if you are age 35-39 and one routine mammogram every year if you are age 40-74. There is no charge if you use a facility that participates in the program's network.

Medicare allows yearly routine mammograms for women ages 40 and older and pays 80 percent of Medicare-approved amount. Check with the testing facility to see if it accepts Medicare assignment.

Pap Test Program

The SHP will pay for a Pap test each year, without any requirement for a deductible or coinsurance, for covered women ages 18-65. This benefit does not include the doctor's office visit or other lab tests. Medicare covers a Pap test, pelvic exam and clinical breast exam *every other year*. (If you are at high risk, you may have one yearly. Check with Medicare for more information.) Medicare pays 100 percent for the test, 80 percent for the exam and collection. Please note that the Standard Plan will pay for Pap tests *every year,* so you may take advantage of this benefit in the years that Medicare does *not* pay.

Maternity Management and Well Child Care Benefits

The State Health Plan offers two programs geared toward early detection and prevention of illness among children. The Maternity Management benefit helps mothers-to-be receive necessary prenatal care. (This benefit applies to covered retirees and their spouses. It does not apply to dependent children.) Covered dependent children ages 18 and younger are eligible for Well Child Care check-ups. On page 52 of your 2008 *Insurance Benefits Guide* is a schedule of routine immunizations for which the plan pays 100 percent when a network doctor provides the services. If your covered child has delayed, or missed, receiving immunizations at the recommended time, the plan will pay for "catch-up" immunizations through age 18 for the vaccines listed.

"CARVE-OUT" METHOD OF CLAIMS PAYMENT

When a retired subscriber is covered by Medicare, Medicare pays first, and the Standard Plan pays second. If your provider accepts the amount Medicare allows as payment in full, the Standard Plan will pay the lesser of:

1. The amount Medicare allows, minus what Medicare reported paying or
2. The amount the State Health Plan allows, minus what Medicare reported paying.

If your provider does not accept the amount Medicare allows as payment in full, the Standard Plan pays the difference between the amount the State Health Plan allows and the amount Medicare reported paying. The Standard Plan will never pay more than the State Health Plan allows. If the Medicare payment is more than the amount the State Health Plan allows, the Standard Plan pays nothing.

***Example**:*
Medicare is primary. The hospital bill for a January admission is $7,500. If you are enrolled in the Standard Plan and Medicare, your Medicare claim will be processed like this:

$7,500	Medicare-approved amount
- 1,024	Medicare Part A deductible for 2008
$6,476	Medicare payment
$1,024	Balance of the bill

Next, Standard Plan benefits are applied to the Medicare-approved amount:

$7,500	State Health Plan allowable charge
- 350	Standard Plan deductible for 2008
$7,150	Standard Plan's responsibility after deductible
x 80%	Standard Plan coinsurance
$5,720	Standard Plan payment
- 6,476	Medicare payment is "carved out" of the Standard Plan payment.
$ 0	Standard Plan pays nothing. You pay $1,024.

Under the carve-out method, you pay the Standard Plan deductible and coinsurance or the balance of the bill, whichever is less. In this example, the $350 deductible and your 20 percent coinsurance is $1,780. However, the balance of the bill is $1,024, so you pay the lesser amount, $1,024.

Once you reach your $2,000 coinsurance maximum, all claims will be calculated at 100 percent of the allowable charge based on the carve-out method of claims payment. All of your Medicare deductibles and your Medicare Part B 20 percent coinsurance should be paid in full for the rest of the calendar year after you reach your $2,000 coinsurance maximum.

FILING CLAIMS AS A RETIREE

If you are retired and enrolled in Medicare, Medicare is your primary carrier. In most cases, your provider will file your Medicare claims for you.

Claims Filed in South Carolina

The Medicare claim should be filed first. Claims for Medicare-approved charges incurred in South Carolina should be transferred automatically from Medicare to the State Health Plan for you. Your mental health and substance abuse provider should file claims for you with APS, including Medicare payment information. If you or your doctor have not received payment or notification from the State Health Plan within 30 days after the Medicare payment is received, one of you must send BlueCross BlueShield of South Carolina, claims administrator for the State Health Plan, a claim form and a copy of your Medicare Summary Notice, formerly called the "Explanation of Medicare Benefits," with your Benefits Identification Number or Social Security Number written on it.

Claims Filed Outside South Carolina

If you receive services outside South Carolina, your provider will file the claim with the Medicare carrier in that state. If you or your doctor have not received payment or notification from the State Health Plan within 30 days after the Medicare payment is received, one of you must send BlueCross BlueShield of South Carolina, third-party administrator for the SHP, a claim form and a copy of your Medicare Summary Notice, formerly called the "Explanation of Medicare Benefits," with your Benefits Identification Number or Social Security Number written on it. For mental health and substance abuse claims, you must send your Medicare Summary Notice to APS Healthcare, Inc.

If Medicare Denies Your Claim

If Medicare denies your claim, including denied Pap test claims, you are responsible for filing the denied claim with BlueCross BlueShield of South Carolina (BCBSSC). You may use the same SHP claim form as active employees do. These forms are available from EIP or BCBSSC. You will need to attach your Medicare Summary Notice, formerly called the "Explanation of Medicare Benefits," and an itemized bill to your claim form.

Railroad Retirement Claims

If you receive benefits from the Railroad Retirement Board (RRB), you must first file claims with the RRB. When you get an explanation of benefits, mail it, along with an itemized bill and claim form, to BlueCross BlueShield of South Carolina for processing.

The Medicare Supplemental Plan

If you are a retiree enrolled in the Standard Plan or the Savings Plan and become eligible for Medicare **due to your age,** you will receive a letter from EIP stating that you will be enrolled automatically in the Medicare Supplemental Plan. If you prefer another health plan, you must inform EIP by responding to the letter within 31 days of Medicare eligibility.

If you are enrolled in a health plan offered through EIP, you may change to the Medicare Supplemental Plan within 31 days of Medicare eligibility. During the yearly October enrollment period, you can change from the Standard Plan or an HMO available in the county in which you live, to the Medicare Supplemental Plan or vice versa. Plan changes are effective on January 1 after the enrollment period.

This section explains the Medicare Supplemental Plan, which is available to retirees and covered dependents who are enrolled in both Parts A and B of Medicare. This plan coordinates benefits with the original Medicare Plan only. **No benefits are provided for coordination with Medicare Advantage Plans.** For more information, visit www.medicare.gov or call 800-633-4227.

General Information

The Medicare Supplemental Plan is similar to a Medigap policy — it "fills the gap" or pays the portion of Medicare-approved charges that Medicare does not, such as Medicare's deductibles and coinsurance. The Medicare Supplemental Plan payment is based on the Medicare-approved amount. Except as specified on pages 12-15, charges that are not covered by Medicare will not be payable as benefits under the Medicare Supplemental Plan.

For example:
In an outpatient setting, such as an emergency room, Medicare does not cover drugs that a person usually administers to himself, such as pills. This means that if a patient receives pain pills in an emergency room, the hospital will bill him for the drugs. Because Medicare does not pay for the pills, the Medicare Supplemental Plan will not pay for them either.

If your medical provider does not accept Medicare assignment, and charges you more than what Medicare allows, you pay the difference.

Using Medi-Call
Medicare has its own program for reviewing use of its services. You need to call Medi-Call only when Medicare benefits are exhausted for inpatient hospital services and for extended care services, such as skilled nursing facilities, private duty nursing, home healthcare, durable medical equipment and Veterans Administration hospital services.

Note: *Any covered family members who are not eligible for Medicare and have their claims processed under the Standard Plan must call Medi-Call.*

MEDICARE DEDUCTIBLES AND COINSURANCE

Deductibles

Medicare Part A has an inpatient hospital deductible for each *benefit period*. That deductible for 2008 is $1,024. A Medicare benefit period begins the day you go to a hospital or skilled nursing facility and ends when you have not received any hospital or skilled care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. *The Medicare Supplemental Plan will pay the Part A deductible each time it is charged.*

Medicare Part B has a deductible of $135 a year in 2008. Part B, for which you pay a monthly premium, covers physician services, supplies and outpatient care. Please contact Medicare for more information. As a retiree, you must enroll in Part B as soon as you are eligible for Medicare, because Medicare is your primary coverage. If you are not enrolled in Part B, you will be required to pay the portion of your healthcare costs that Part B would have paid. *The Medicare Supplemental Plan pays the Part B deductible.*

Coinsurance

Medicare Part B pays 80 percent of the Medicare-approved amount (50 percent for outpatient mental healthcare). *The Medicare Supplemental Plan pays the remaining 20 percent (50 percent for outpatient mental healthcare).*

MEDICARE SUPPLEMENTAL PLAN DEDUCTIBLES AND COINSURANCE

The Medicare Supplemental Plan benefit period is from January 1-December 31 and includes a $200 deductible each calendar year that applies to private duty nursing services only. If you become eligible for Medicare and change to the Medicare Supplemental Plan during the year, you must meet a new $200 deductible for private duty nursing services. You do not have to meet another $200 deductible for private duty nursing services if you remain enrolled in the Standard Plan.

WHAT THE MEDICARE SUPPLEMENTAL PLAN COVERS

Hospital Admissions

The Medicare Supplemental Plan pays these expenses for Medicare-covered services after Medicare Part A benefits have been paid during a benefit period:

- The Medicare Part A hospital deductible
- The coinsurance, after Medicare pays, for days 61-150 of hospitalization, up to the Medicare-approved amount (Medicare pays 100 percent for the first 60 days)
- 100 percent of the Medicare-approved amount for hospitalization through 60 days if you have used up your lifetime reserve and if medically necessary*
- The coinsurance for durable medical equipment up to the Medicare-approved amount.

**Must call Medi-Call or APS for approval.*

Additional Days in a Hospital

If you are enrolled in Medicare, Medicare is the primary payer, and you may go to any hospital you choose. However, Medicare pays nothing for hospital stays beyond 150 days.

If You Exceed the Number of Inpatient Hospital Days Allowed Under Medicare
If you are enrolled in the Medicare Supplemental Plan and you exhaust all Medicare-allowed inpatient hospital days, you must call Medi-Call for approval of any additional inpatient hospital days. If your extended stay is approved, the Medicare Supplemental Plan will pay for the Medicare-approved expenses. So, if you are enrolled in the Medicare Supplemental Plan and you expect your hospital stay may exceed the number of days allowed under Medicare, you should choose a hospital within the SHP network or BlueCard Program so that any additional days beyond what Medicare allows will be covered by the Medicare Supplemental Plan.

You must also call Medi-Call for services related to home healthcare, hospice, durable medical equipment and Veterans Administration hospital services.

Skilled Nursing Facilities

The Medicare Supplemental Plan will pay these benefits after Medicare has paid benefits during a benefit period:

- The coinsurance, after Medicare pays, up to the Medicare-approved amount for days 21-100 (Medicare pays 100 percent for the first 20 days)
- 100 percent of the Medicare-approved rates beyond 100 days in a skilled nursing facility if medically necessary. (Medicare does not pay beyond 100 days.)* The maximum benefit per year for covered services beyond 100 days is $6,000.

**Must call Medi-Call for approval.*

Physician Charges

The Medicare Supplemental Plan will pay these benefits related to physician services approved by Medicare:

- The Medicare Part B deductible
- The coinsurance for the Medicare-approved amount for physician's services for surgery, necessary home and office visits, hospital visits and other covered physician's services
- The coinsurance for the Medicare-approved amount for physician's services rendered in the outpatient department of a hospital for treatment of accidental injury, medical emergencies, minor surgery and diagnostic services.

Home Healthcare

The Medicare Supplemental Plan will pay these benefits for medically necessary home healthcare services:

- The Medicare Part B deductible
- The coinsurance for any covered services or costs Medicare does not cover (Medicare pays 100 percent of Medicare-approved amount), up to 100 visits or $5,000 per benefit year, whichever occurs first. The plan does not cover services provided by a person who ordinarily resides in the home, is a member of the family or a member of the family of the spouse of the covered person
- 20 percent of Medicare-approved amount for durable medical equipment.

Private Duty Nursing Services

Private duty nursing services are services that are provided by a registered nurse (RN) or a licensed practical nurse (LPN) and that have been certified in writing by a physician as medically necessary. There is a $200 annual deductible that applies, regardless of the time of year you enroll in the plan. Medicare does NOT cover this service. Once the deductible is met, the Medicare Supplemental Plan will pay 80 percent of covered charges for private duty nursing in a hospital or in the home. Coverage is limited to no more than three nurses per day, and the maximum annual benefit per year is $5,000. The lifetime maximum benefit under the Medicare Supplemental Plan is $25,000.

Prescription Drugs

The Medicare Supplemental Plan covers prescription drugs when purchased from a participating pharmacy under the State Health Plan's Prescription Drug Program, managed by Medco. For more information, refer to your 2008 *Insurance Benefits Guide*.

When Traveling Outside the U.S.

Medicare does not cover services outside the United States and its territories. Because the Medicare Supplemental Plan does not allow benefits for services not covered by Medicare (other than private duty nursing), out-of-country services are not covered for Medicare Supplemental Plan subscribers.

Mental Health and Substance Abuse Services

If your claims are processed under the Medicare Supplemental Plan, you are encouraged, but not required, to call APS, the SHP's behavioral health manager, because Medicare guidelines will apply. However, if you exhaust Medicare's allowed inpatient hospital days, you must call APS for approval of any additional inpatient hospital days, including those in Veterans Administration hospitals. However, you are not required to use an APS network provider.

Note: *Any covered family members who are not eligible for Medicare and have their claims processed under the Standard Plan must call to register with APS and must use an APS network provider.*

Pap Test Benefit

If you are enrolled in Medicare, Medicare covers a Pap test, pelvic exam and clinical breast exam every other year. (These tests are covered yearly if you are at high risk. Check with Medicare for more information.) Medicare pays 100 percent for the Pap lab test and 80 percent of the Medicare-approved amount for the Pap test collection and the pelvic and breast exam. The Medicare Supplemental Plan pays the 20 percent coinsurance.

Please note that the Medicare Supplemental Plan will pay for a Pap test each year, without any requirement for a deductible or coinsurance, for covered women, ages 18-65. You may take advantage of this benefit in the years that Medicare does *not* pay. The deductible and coinsurance do not apply to this benefit. This benefit does not include the doctor's office visit or other lab tests.

Medicare Assignment: How Medicare Pays Its Share of the Cost of Your Care

If the provider accepts Medicare assignment, the provider accepts Medicare's payment plus the Medicare Supplemental Plan's payment as payment in full. If the provider does not accept Medicare assignment, the provider may charge more than what Medicare and the Medicare Supplemental Plan pay combined. You pay the difference.

Example:
Medicare is primary. The hospital bill for a January admission is submitted to Medicare. If you are enrolled in Medicare and the Medicare Supplemental Plan, your Medicare claim will be processed like this:

$7,500	Medicare-approved amount
-1,024	Medicare Part A deductible for 2008
$6,476	Medicare payment
$1,024	Balance of the bill

Next, the Medicare Supplemental Plan benefits are applied:

$1,024	Balance of the bill
-$1,024	Medicare Supplemental Plan pays Medicare Part A deductible
$ 0	You pay nothing.

Filing Medicare Claims as a Retiree

If you are retired and enrolled in Medicare, Medicare is your primary carrier. In most cases, your provider will file your Medicare claims for you.

Claims Filed in South Carolina

The Medicare claim should be filed first. Claims for Medicare-approved charges incurred in South Carolina should be transferred automatically from Medicare to the State Health Plan for you. Your mental health and substance abuse provider should file claims to APS with Medicare payment information. If you or your doctor have not received payment or notification from the plan within 30 days after the Medicare payment is received, one of you must send BlueCross BlueShield of South Carolina, claims administrator for the SHP, a claim form and a copy of your Medicare Summary Notice, formerly called the "Explanation of Medicare Benefits," with your Benefits ID Number or Social Security Number written on it.

Claims Filed Outside South Carolina

If you receive services outside South Carolina, your provider will file its claim to the Medicare carrier in that state. When you receive your Medicare Summary Notice, formerly called the "Explanation of Medicare Benefits," you must send it to BlueCross BlueShield of South Carolina for medical or surgical services or to APS for mental health and substance abuse services. You also must include a claim form and an itemized bill.

Medical Care Outside the United States and Its Territories

Remember that the Medicare Supplemental Plan follows Medicare rules. Because Medicare does not provide coverage outside the U.S. and its territories, BlueCard Worldwide® coverage **is not** available to Medicare Supplemental Plan subscribers.

Railroad Retirement Claims

If you receive benefits from the Railroad Retirement Board (RRB), you must first file claims with the RRB. When you get an explanation of benefits from the RRB, mail it, along with an itemized bill and claim form, to BlueCross BlueShield of South Carolina for processing.

Filing Claims for Covered Family Members not Eligible for Medicare

Claims for covered family members who are not eligible for Medicare, but who are insured through the Medicare Supplemental Plan, are paid according to the Standard Plan provisions. Remember that some services require preauthorization by Medi-Call (see page 7) or APS Healthcare (see page 8).

HMO Plans

This section explains some key distinctions of the health maintenance organizations (HMOs) and how they work together with Medicare. For a more complete overview of the plans, refer to your 2008 *Insurance Benefits Guide* or contact the HMO.

An HMO typically does not cover care outside its network, except in an emergency. If it is important to you to use particular providers, including physicians and hospitals, it is best to check to see if those providers participate in the HMO you wish to join. Remember, you must live in an HMO's service area to enroll. Not all HMOs are available in all South Carolina counties. Below is a list of counties in which each HMO is available:

- **BlueChoice HealthPlan** is available in all South Carolina counties.
- **CIGNA HMO** is available in all South Carolina counties ***except*** *Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick* and *Saluda*.
- **MUSC Options** is available in these South Carolina counties: Berkeley, Charleston, Colleton and Dorchester.

IF YOU ARE ELIGIBLE FOR MEDICARE

BlueChoice HealthPlan, CIGNA HMO and MUSC Options are available if you live in a county where they are offered. This section will focus on these plans.

Provider Networks

A traditional HMO provides a list of participating network doctors from which you choose a primary care physician. This doctor coordinates your care, which means you must contact him to be referred to specialists who also participate in the HMO's network. Network providers file the claims for you. If you belong to an HMO, the plan covers only medical services received from network providers. If you receive care outside the network, benefits are not paid. Typically, the only services from out-of-network providers that most HMOs cover are those for medical emergencies.

When Traveling Outside the Network or the U.S.

When traveling outside the CIGNA, MUSC Options or BlueChoice HealthPlan networks, you will be covered for emergency medical care. If your insurance identification cards are not recognized by the hospital, you may be required to pay for the services and then later file a claim for reimbursement.

Prescription Drug Programs

Each HMO offered for 2008 includes a prescription drug program with participating pharmacies.

HOW BLUECHOICE HEALTHPLAN AND MEDICARE WORK TOGETHER

BlueChoice HealthPlan pays only charges approved by Medicare. It supplements Medicare by paying the Medicare Part A (hospital) and Part B (medical) deductibles in full. The plan also pays the 20 percent coinsurance left after Medicare pays 80 percent for approved Part B services.

When you become eligible for Medicare, it is important to be enrolled in Part B if you are covered as a retiree or as a dependent of a retiree. Medicare becomes your primary insurance, and your health plan offered through EIP becomes the secondary payer. If you are not enrolled in Part B, you will be required to pay the portion of your healthcare costs that Part B would have paid.

This plan pays the coinsurance for hospitalization after the first 60 days in a general hospital or after the first 20 days in a skilled nursing facility. (Medicare pays 100 percent of the Medicare-approved amount for the first 60 days in a general hospital and for the first 20 days of skilled nursing care.) BlueChoice HealthPlan also pays the Medicare coinsurance for days 21-100 for skilled nursing care.

If the provider accepts Medicare assignment, the provider will consider Medicare's payment plus BlueChoice HealthPlan's as payment in full. If the provider does not accept Medicare assignment, the provider may charge more than what Medicare and BlueChoice HealthPlan pay combined. You pay the difference.

Example:
Medicare is primary. The bill is submitted to Medicare for a January hospital admission:

$7,500	Hospital bill
-1,024	Medicare Part A deductible for 2008
$6,476	Medicare payment
$1,024	Balance of the bill

BlueChoice HealthPlan pays all Medicare deductibles and coinsurance:

$1,024	BlueChoice HealthPlan pays Medicare Part A deductible
+6,476	Amount paid by Medicare
$7,500	Bill paid in full

If you are retired and enrolled in Medicare, Medicare is your primary coverage. In most cases, your provider will file your Medicare claims for you. The Medicare claim should be filed first.

Refer to your 2008 *Insurance Benefits Guide* for additional information about BlueChoice HealthPlan.

HOW CIGNA HMO AND MEDICARE WORK TOGETHER

CIGNA HMO pays the lesser of the subscriber's unreimbursed allowable charge under Medicare or CIGNA's normal liability. If the balance due on the claim is less than the normal liability, then CIGNA will pay the balance due.

CIGNA's benefit credit saving provisions apply. A *benefit credit* is the portion of the claim that CIGNA does not have to pay as a result of coordination of benefits with Medicare. It may be applied to future claims during the calendar year. *Benefit credit saving* is the difference between what CIGNA would normally be responsible for paying and CIGNA's actual payment. It applies only to the family member who incurs the charge, and it expires at the end of the calendar year in which it is gained. Contact CIGNA for additional information.

Example:
Medicare is primary. The bill is submitted to Medicare for a January hospital admission:

$7,500	Hospital bill
- 1,024	Medicare Part A deductible for 2008
$6,476	Medicare payment
$1,024	Balance of the bill

If you are enrolled in CIGNA's HMO plan your claim will be paid like this:

$7,500	Hospital bill
- 500	CIGNA's inpatient per occurrence copayment
$7,000	
x 80%	CIGNA's coinsurance
$5,600	CIGNA's liability in absence of Medicare
- 1,024	Amount paid by CIGNA in coordination with Medicare
$4,576	Benefit credit savings with CIGNA

Filing Claims as a Retiree

If you are retired and enrolled in Medicare, Medicare is your primary coverage. In most cases, your provider will file your Medicare claims for you. The Medicare claim should be filed first.

For more information, contact CIGNA.

HOW MUSC OPTIONS AND MEDICARE WORK TOGETHER

MUSC Options is available to Medicare recipients living in Berkeley, Charleston, Colleton and Dorchester counties. The health maintenance organization with a point of service option pays only charges approved by Medicare. It supplements Medicare by paying the Medicare Part A (hospital) and Part B (medical) deductibles in full. The plan also pays the 20 percent coinsurance left after Medicare pays 80 percent for Part B-approved services.

MUSC Options pays the coinsurance for hospitalization after the first 60 days in a general hospital or after the first 20 days in a skilled nursing facility. (Medicare pays 100 percent of the Medicare-approved amount for the first 60 days in a general hospital and for the first 20 days of skilled nursing care.) It also pays the Medicare coinsurance for days 21-100 for skilled nursing care.

If the provider accepts Medicare assignment, the provider will consider Medicare's payment plus MUSC Options' as payment in full. If the provider does not accept Medicare assignment, the provider may charge more than what Medicare and MUSC Options pay combined. The subscriber would pay the difference.

Example:
Medicare is primary. The bill is submitted to Medicare for a January hospital admission:

$7,500	Hospital bill
- 1,024	Medicare Part A deductible for 2008
$6,476	Medicare payment
$1,024	Balance of the bill

MUSC Options pays all Medicare deductibles and coinsurance:

$1,024	MUSC Options pays Medicare Part A deductible
+6,476	Amount paid by Medicare
$7,500	Bill paid in full

If you are retired and enrolled in Medicare, Medicare is your primary coverage. In most cases, your provider will file your Medicare claims for you. The Medicare claim should be filed first.

Please refer to your 2008 *Insurance Benefits Guide* for additional information about MUSC Options.

Comparison of Health Plans for Retirees

Type			PPO To receive a higher level of benefits, subscribers should choose an in-network provider.
Plan	**Medicare**	**Medicare Supplemental**	**SHP Standard Plan**
Availability	United States (Contact Medicare for information about any services outside of the United States)	Same as Medicare	Coverage worldwide
Cancellation Policy	None	Canceled upon request or for non-payment of premiums	Canceled upon request or for non-payment of premiums
Annual Deductible	Part A: **$1,024** (per benefit period) Part B: **$135**	Pays Medicare Part A and Part B deductibles	**$350** (single) **$700** (family) Carve-out method applies
Per-occurrence Deductible	Inpatient hospital: Part A deductible (**$1,024** per benefit period)	Pays Medicare Part A deductible (Call Medi-Call for hospital stays over 150 days, skilled nursing, private duty nursing, home healthcare, durable medical equipment and VA hospital services)	Outpatient hospital: **$75** deductible Emergency care: **$125** deductible (Call Medi-Call for hospital stays over 150 days, skilled nursing, private duty nursing, home healthcare, durable medical equipment and VA hospital services)
Coinsurance	Part A: 100% Part B: 80% (You pay 20%)	Pays Part B coinsurance of 20%	Carve-out method applies Plan allows 80%
Coinsurance Maximum	None	None	**In-network** **$2,000** (single) **$4,000** (family) **Out-of-network** **$4,000** (single) **$8,000** (family) Excludes deductible
Physician Visits	Plan pays 80% You pay 20% Routine annual physicals and OB/GYN exams not covered	Plan pays Part B coinsurance of 20%	Carve-out method applies; **$10** per-occurrence deductible; Plan allows 80% in-network, 60% out-of-network Well Child Care visits and immunizations paid at 100% in-network up to age 18.
Prescription Drugs	Covered under Medicare Part D. However, subscribers to health plans offered through the Employee Insurance Program have creditable coverage and therefore typically do not need to sign up for Part D.	Participating pharmacies only (up to 31-day supply): **$10** tier 1 (generic—lowest cost), **$25** tier 2 (brand—higher cost), **$40** tier 3 (brand—highest cost) Mail-order (up to 90-day supply): **$25** tier 1, **$62** tier 2, **$100** tier 3 Copay max: **$2,500**	Participating pharmacies only (up to 31-day supply): **$10** tier 1 (generic—lowest cost), **$25** tier 2 (brand—higher cost), **$40** tier 3 (brand—highest cost) Mail order (up to 90-day supply): **$25** tier 1, **$62** tier 2, **$100** tier 3 Copay max: **$2,500**
Mental Health/ Substance Abuse	Inpatient: Plan pays 100% for days 1-60 (Part A deductible applies); You pay **$256**/day for days 61-90; You pay **$512**/day for days 91-150 (subject to 60 lifetime reserve days); You pay all costs after 150 days. Outpatient: Plan pays 50% (Part B deductible applies)	Inpatient: Plan pays Medicare deductible; **$256** coinsurance for days 61-90; **$512** coinsurance for days 91-150; 100% after 150 days (APS approval required). Outpatient: Plan pays Medicare deductible, 50% coinsurance	Carve-out method applies Plan allows 80% in-network (APS participating providers only if hospital stay exceeds 150 days)
Lifetime Maximum	**None**	**$1,000,000**	**$1,000,000**

and Dependents Eligible for Medicare

	Traditional HMO		HMO with a Point of Service Option (POS)	
	All care must be directed by a primary care physician (PCP) and approved by the HMO.		Medically necessary benefits are available out-of-network at a lower benefit.	
	BlueChoice HealthPlan	**CIGNA HMO**	**MUSC Options**	
	Available in all South Carolina counties	Available in all S.C. counties, **except**: *Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick and Saluda*	Available in these S.C. counties: *Berkeley, Charleston, Colleton and Dorchester*	
	Canceled upon request or for non-payment of premiums	Canceled upon request or for non-payment of premiums	Canceled upon request or for non-payment of premiums	
	Pays Medicare Part A and Part B deductibles	No deductible; Pays lesser of unreimbursed Medicare-allowed expenses or plan's normal allowable charge	Pays Medicare Part A and Part B deductibles	
	Pays Medicare Part A deductible	Inpatient: **$500** copay Outpatient facility: **$250** copay Emergency care: **$100** copay	Pays Medicare Part A deductible	
	Pays Part B coinsurance of 20%	Plan pays 80% of unreimbursed Medicare-allowed expenses.	Pays Part B coinsurance of 20%	
	None	**$2,000** (single) **$4,000** (family) (excludes certain copays)	**<u>In-network</u>** None	**<u>Out-of-network</u>** **$3,000** (single) **$9,000** (family) (excludes deductibles)
	Plan pays Part B coinsurance of 20%	**$15** PCP copay **$15** OB/GYN exam **$30** specialist copay Plan pays 80% of unreimbursed Medicare-allowed charges	Plan pays Part B coinsurance of 20%	HMO pays 60% of allowance after annual deductible You pay 40% No preventive care benefits out-of-network
	Participating pharmacies only (up to 30-day supply): **$7** generic **$35** preferred brand **$55** non-preferred brand **$100** specialty pharmaceuticals Mail order (up to 90-day supply): **$14** generic **$70** preferred brand **$110** non-preferred brand	Participating pharmacies only (up to 30-day supply): **$7** generic **$25** preferred brand **$50** non-preferred brand Mail-order (up to 90-day supply): **$14** generic **$50** preferred brand **$100** non-preferred brand No copay max	Participating pharmacies only (up to 30-day supply): **$100** deductible, then: **$10** tier 1 (generic—lowest cost), **$30** tier 2 (brand—higher cost), **$50** tier 3 (brand—highest cost), **$100** specialty pharmaceuticals Mail order (up to 90-day supply): **$25** tier 1, **$75** tier 2, **$125** tier 3	
	Inpatient: Plan pays Medicare deductible; **$256** coinsurance for days 61-90; **$512** coinsurance for days 91-150; 100% beyond 150 days Outpatient: Plan pays Medicare deductible, 50% coinsurance	Participating providers only: **$40** copay per office visit Inpatient: **$500** copay per admission Plan pays 80% of unreimbursed Medicare-allowed expenses	Inpatient: Plan pays Medicare deductible; **$256** coinsurance for days 61-90; **$512** coinsurance for days 91-150; 100% beyond 150 days Outpatient: Plan pays Medicare deductible, 50% coinsurance	
	$1,000,000	**$1,000,000**	**$1,000,000**	

Comparison of Health Plan Benefits for Retirees

Plan	Medicare	Medicare Supplemental	SHP Standard Plan	
Inpatient Hospital Days	Plan pays 100% for days 1-60 (Part A deductible applies); You pay **$256**/day for days 61-90; You pay **$512** for days 91-150 (subject to 60 lifetime reserve days); You pay all costs beyond 150 days	Plan pays: Medicare deductible; **$256** coinsurance for days 61-90; **$512** coinsurance for days 91-150; 100% beyond 150 days (Medi-Call approval required)	Carve-out method applies Plan allows 80% (Call Medi-Call if hospital stay exceeds 150 days)	
Skilled Nursing Care	Plan pays 100% for days 1-20; You pay **$128** for days 21-100	Plan pays **$128** for days 21-100; Plan pays 100% beyond 100 days (Medi-Call approval required) up to **$6,000** or 60 days, whichever is less	Carve-out method applies Plan allows 80%, up to **$6,000** or 60 days, whichever is less. (Call Medi-Call if hospital stay exceeds 100 days)	
Private Duty Nursing	Not covered	**$200** annual deductible Plan pays 80% if Medi-Call approved You pay 20% **$5,000** annual maximum **$25,000** lifetime maximum	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call approval required)	
Home Healthcare	Plan pays 100%	Medi-Call available to assist with referrals Up to **$5,000** or 100 visits, whichever is less	Carve-out method applies Plan allows 80% You pay 20% up to **$5,000** or 100 visits, whichever is less	
Hospice Care	Plan pays 100%	Medi-Call available to assist with referrals	Medi-Call available to assist with referrals	
Durable Medical Equipment	Plan pays 80% (Medicare approval required) You pay 20%	Plan pays 20% coinsurance (Medi-Call required)	Carve-out method applies Plan allows 80% (Medi-Call approval required)	
Routine Mammography Screening	Age 40 and older, one every year Plan pays 80% You pay 20%	Plan pays 20% coinsurance	Ages 35-74 in participating facilities only; guidelines apply	
Pap Test	Routine every two years (yearly if high risk) Plan pays 100% for Pap test Plan pays 80% for exam	Plan pays 20% coinsurance. Otherwise, plan pays yearly for one routine Pap test for covered women ages 18-65. Diagnostic only age 66 and older.	Routine yearly ages 18-65; Diagnostic only age 66 and older; Plan allows 100% for Pap test (Carve-out method applies when Medicare pays)	
Ambulance	Plan pays 80% You pay 20%	Plan pays 20% coinsurance	Carve-out method applies Plan allows 80%	
Eyeglasses/ Hearing Aid	None, except for prosthetic lenses from cataract surgery. Discount under the Vision Care Program	None, except for prosthetic lenses from cataract surgery. Discount under the Vision Care Program	None, except for prosthetic lenses from cataract surgery. Discount under the Vision Care Program	

Please note: *This chart is just a summary of your benefits. Please consult the Retirement/Disability Retirement and Health Insurance chapters of your 2008* Insurance Benefits Guide *for details.*

and Dependents Eligible for Medicare (cont.)

	BlueChoice HealthPlan	CIGNA HMO	MUSC Options
	Plan pays: Medicare deductible; **$256** coinsurance for days 61-90; **$512** coinsurance for days 91-150; 100% beyond 150 days	Plan pays 80% or unreimbursed Medicare-allowed expenses after **$500** copay	Plan pays: Medicare deductible; **$256** coinsurance for days 61-90; **$512** coinsurance for days 91-150; 100% beyond 150 days
	Plan pays **$128** for days 21-100; Plan pays 100% beyond 100 days (limited to 120 days)	Plan pays 80% or unreimbursed Medicare-allowed expenses, up to 180 days	Plan pays **$128** for days 21-100; Plan pays 100% beyond 100 days (limited to 120 days)
	Plan pays 80%; You pay 20% and **$200** annual deductible **$5,000** annual maximum **$25,000** lifetime maximum (limited to 120 days)	Plan pays 100%	Plan pays 80%; You pay 20% and **$200** annual deductible **$5,000** annual maximum **$25,000** lifetime maximum (limited to 120 days)
	(Medicare pays 100% of covered charges)	Plan pays 100% or unreimbursed Medicare-allowed expenses, up to 60 visits	(Medicare pays 100% of covered charges)
	(Medicare pays 100% of covered charges)	Plan pays 100% or unreimbursed Medicare-allowed expenses	(Medicare pays 100% of covered charges)
	Plan pays 20% coinsurance	**$3,500** maximum Plan pays 100% or unreimbursed Medicare-allowed expenses	Plan pays 20% coinsurance
	Plan pays 20% coinsurance	Plan pays 100% or unreimbursed Medicare-allowed expenses	Plan pays 20% coinsurance
	Plan pays 20% coinsurance. Otherwise, pays routine OB/GYN exam two times per year after **$15** copay. Diagnostic: copay/coinsurance	Plan pays 100% or unreimbursed Medicare-allowed expenses after **$15** copay	Plan pays 20% coinsurance. Otherwise, pays routine OB/GYN exam after **$25** copay. Diagnostic: **$50** copay
	Plan pays 20% coinsurance	Plan pays 90% or unreimbursed Medicare-allowed expenses	Plan pays 20% coinsurance
	One exam for glasses or contacts per year (**$45** copay for contacts exam). One pair of glasses every other year (from designated selection)	One exam every two years (**$10** copay) Must use a participating provider	One exam for glasses or contacts per year (**$45** copay for contacts exam). One pair of glasses every other year (from designated selection)

2008 Regular Retiree (State-funded Benefits) Monthly Premiums[1] (Retiree eligible for Medicare/spouse eligible for Medicare)								
	Savings	**Standard**	**Medicare Supplemental[2]**	**BlueChoice HealthPlan**	**CIGNA HMO**	**MUSC Options**	**Dental**	**Dental Plus**
Retiree	N/A	$ 75.46	$ 93.46	$129.60	$136.30	$194.82	$ 0.00	$20.60
Retiree/spouse	N/A	$201.50	$237.50	$380.50	$390.94	$508.68	$ 7.64	$39.00
Retiree/children	N/A	$124.46	$142.46	$282.14	$288.66	$345.76	$13.72	$42.56
Full family	N/A	$258.58	$294.58	$566.48	$577.34	$644.66	$21.34	$60.96
(Retiree eligible for Medicare/spouse **not** eligible for Medicare)								
	Savings	**Standard**	**Medicare Supplemental[2]**	**BlueChoice HealthPlan**	**CIGNA HMO**	**MUSC Options**	**Dental**	**Dental Plus**
Retiree/spouse	N/A	$219.50	$237.50	$380.50	$390.94	$508.68	$ 7.64	$39.00
Full family	N/A	$268.50	$286.50	$566.48	$577.34	$644.66	$21.34	$60.96
(Retiree **not** eligible for Medicare/spouse eligible for Medicare)								
	Savings	**Standard**	**Medicare Supplemental[2]**	**BlueChoice HealthPlan**	**CIGNA HMO**	**MUSC Options**	**Dental**	**Dental Plus**
Retiree/spouse	$ 72.56	$219.50	$237.50	$380.50	$390.94	$508.68	$ 7.64	$39.00
Full family	$108.56	$268.50	$286.50	$566.48	$577.34	$644.66	$21.34	$60.96
(Retiree **not** eligible for Medicare/spouse **not** eligible for Medicare)								
	Savings	**Standard**	**Medicare Supplemental[2]**	**BlueChoice HealthPlan**	**CIGNA HMO**	**MUSC Options**	**Dental**	**Dental Plus**
Retiree	$ 9.28	$ 93.46	N/A	$129.60	$136.30	$194.82	$ 0.00	$20.60
Retiree/spouse	$ 72.56	$237.50	N/A	$380.50	$390.94	$508.68	$ 7.64	$39.00
Retiree/children	$ 20.28	$142.46	N/A	$282.14	$288.66	$345.76	$13.72	$42.56
Full family	$108.56	$294.58	N/A	$566.48	$577.34	$644.66	$21.34	$60.96
(Retiree **not** eligible for Medicare/spouse **not** eligible for Medicare/one or more children eligible for Medicare)								
	Savings	**Standard**	**Medicare Supplemental[2]**	**BlueChoice HealthPlan**	**CIGNA HMO**	**MUSC Options**	**Dental**	**Dental Plus**
Retiree/children	$ 20.28	$142.46	$160.46	$282.14	$288.66	$345.76	$13.72	$42.56
Full family	$108.56	$294.58	$312.58	$566.48	$577.34	$644.66	$21.34	$60.96

[1]Rates for local subdivisions may vary. To verify your rates, contact your benefits office.
[2]If the Medicare Supplemental Plan is elected, claims for covered persons not eligible for Medicare will be based on the Standard Plan provisions.

Note: These premiums are valid from January 1, 2008, through December 31, 2008. Premiums are subject to change after this period.

2008 Retiree Full Cost (Non-funded) Monthly Premiums[1] (Retiree eligible for Medicare/spouse eligible for Medicare)								
	Savings	**Standard**	**Medicare Supplemental[2]**	**BlueChoice HealthPlan**	**CIGNA HMO**	**MUSC Options**	**Dental**	**Dental Plus**
Retiree	N/A	$336.36	$354.36	$ 390.50	$ 397.20	$ 455.72	$11.71	$20.60
Retiree/spouse	N/A	$716.20	$752.20	$ 895.20	$ 905.64	$1,023.38	$19.35	$39.00
Retiree/children	N/A	$493.60	$511.60	$ 651.28	$ 657.80	$ 714.90	$25.43	$42.56
Full family	N/A	$861.14	$897.14	$1,169.04	$1,179.90	$1,247.22	$33.05	$60.96
(Retiree eligible for Medicare/spouse **not** eligible for Medicare)								
	Savings	**Standard**	**Medicare Supplemental[2]**	**BlueChoice HealthPlan**	**CIGNA HMO**	**MUSC Options**	**Dental**	**Dental Plus**
Retiree/spouse	N/A	$734.20	$752.20	$ 895.20	$ 905.64	$1,023.38	$19.35	$39.00
Full family	N/A	$871.06	$889.06	$1,169.04	$1,179.90	$1,247.22	$33.05	$60.96
(Retiree **not** eligible for Medicare/spouse eligible for Medicare)								
	Savings	**Standard**	**Medicare Supplemental[2]**	**BlueChoice HealthPlan**	**CIGNA HMO**	**MUSC Options**	**Dental**	**Dental Plus**
Retiree/spouse	$587.26	$734.20	$752.20	$ 895.20	$ 905.64	$1,023.38	$19.35	$39.00
Full family	$711.12	$871.06	$889.06	$1,169.04	$1,179.90	$1,247.22	$33.05	$60.96
(Retiree **not** eligible for Medicare/spouse **not** eligible for Medicare)								
	Savings	**Standard**	**Medicare Supplemental[2]**	**BlueChoice HealthPlan**	**CIGNA HMO**	**MUSC Options**	**Dental**	**Dental Plus**
Retiree	$270.18	$354.36	N/A	$ 390.50	$ 397.20	$ 455.72	$11.71	$20.60
Retiree/spouse	$587.26	$752.20	N/A	$ 895.20	$ 905.64	$1,023.38	$19.35	$39.00
Retiree/children	$389.42	$511.60	N/A	$ 651.28	$ 657.80	$ 714.90	$25.43	$42.56
Full family	$711.12	$897.14	N/A	$1,169.04	$1,179.90	$1,247.22	$33.05	$60.96
(Retiree **not** eligible for Medicare/spouse **not** eligible for Medicare/one or more children eligible for Medicare)								
	Savings	**Standard**	**Medicare Supplemental[2]**	**BlueChoice HealthPlan**	**CIGNA HMO**	**MUSC Options**	**Dental**	**Dental Plus**
Retiree/children	$389.42	$511.60	$529.60	$ 651.28	$ 657.80	$ 714.90	$25.43	$42.56
Full family	$711.12	$897.14	$915.14	$1,169.04	$1,179.90	$1,247.22	$33.05	$60.96

[1]Rates for local subdivisions may vary. To verify your rates, contact your benefits office.
[2]If the Medicare Supplemental Plan is elected, claims for covered persons not eligible for Medicare will be based on the Standard Plan provisions.

Note: These premiums are valid from January 1, 2008, through December 31, 2008. Premiums are subject to change after this period.

2008 Survivor Monthly Premiums[1] (Spouse eligible for Medicare/children eligible for Medicare)								
	Savings	**Standard**	**Medicare Supplemental[2]**	**BlueChoice HealthPlan**	**CIGNA HMO**	**MUSC Options**	**Dental**	**Dental Plus**
Spouse	N/A	$336.36	$354.36	$390.50	$397.20	$455.72	$11.71	$20.60
Spouse/children	N/A	$493.60	$529.60	$651.28	$657.80	$714.90	$25.43	$42.56
Children only	N/A	$157.24	$175.24[3]	$260.78	$260.60	$259.18	$13.72	$21.96
(Spouse eligible for Medicare/children **not** eligible for Medicare)								
	Savings	**Standard**	**Medicare Supplemental[2]**	**BlueChoice HealthPlan**	**CIGNA HMO**	**MUSC Options**	**Dental**	**Dental Plus**
Spouse	N/A	$336.36	$354.36	$390.50	$397.20	$455.72	$11.71	$20.60
Spouse/children	N/A	$493.60	$511.60	$651.28	$657.80	$714.90	$25.43	$42.56
Children only	$119.24	$157.24	N/A	$260.78	$260.60	$259.18	$13.72	$21.96
(Spouse **not** eligible for Medicare/children eligible for Medicare)								
	Savings	**Standard**	**Medicare Supplemental[2]**	**BlueChoice HealthPlan**	**CIGNA HMO**	**MUSC Options**	**Dental**	**Dental Plus**
Spouse	$270.18	$354.36	N/A	$390.50	$397.20	$455.72	$11.71	$20.60
Spouse/children	$389.42	$511.60	$529.60[3]	$651.28	$657.80	$714.90	$25.43	$42.56
Children only	N/A	$157.24	$175.24[3]	$260.78	$260.60	$259.18	$13.72	$21.96
(Spouse **not** eligible for Medicare/children **not** eligible for Medicare)								
	Savings	**Standard**	**Medicare Supplemental[2]**	**BlueChoice HealthPlan**	**CIGNA HMO**	**MUSC Options**	**Dental**	**Dental Plus**
Spouse	$270.18	$354.36	N/A	$390.50	$397.20	$455.72	$11.71	$20.60
Spouse/children	$389.42	$511.60	N/A	$651.28	$657.80	$714.90	$25.43	$42.56
Children only	$119.24	$157.24	N/A	$260.78	$260.60	$259.18	$13.72	$21.96

[1]Rates for local subdivisions may vary. To verify your rates, contact your benefits office.
[2]If the Medicare Supplemental Plan is elected, claims for covered subscribers not eligible for Medicare will be based on the Standard Plan provisions.
[3]This premium applies only if one or more children are eligible for Medicare.

Note: These premiums are valid from January 1, 2008, through December 31, 2008. Premiums are subject to change after this period.

Part D Creditable Coverage Letter

Important Notice from the Employee Insurance Program (EIP) About Your State Prescription Drug Coverage and Medicare

On January 1, 2006, Medicare began offering a prescription drug plan, Medicare Part D. The drug coverage most subscribers have through health plans offered by the Employee Insurance Program is as good as, or better than, drug coverage offered by Part D. Therefore, they do not need to sign up for Part D. Subscribers are sent this letter to let them know that they have what Medicare calls "creditable coverage."

The Employee Insurance Program has determined that the prescription drug coverage offered by the Employee Insurance Program is, on average for all participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

Please read this notice, your creditable coverage letter, carefully and keep it where you can find it. This notice contains the following:

1. **Information about your prescription drug coverage with EIP and about prescription drug coverage that became available January 1, 2006, to people with Medicare.**
2. **Medicare Part D prescription drug coverage is available to all people on Medicare.**
3. **EIP has determined that the state drug coverage offered through your health plan (the Standard Plan, the Medicare Supplemental Plan, BlueChoice HealthPlan, CIGNA Healthcare HMO or MUSC Options) is, on average for all plan participants, as good as or better than the standard Medicare prescription drug coverage.**
4. **This notice explains options you have under Medicare prescription drug coverage and can help you decide whether or not to enroll.**

Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans might offer more coverage for a higher monthly premium.

If you enroll in a Medicare prescription drug plan, you will lose your state drug coverage through EIP. Before deciding to switch to Medicare drug coverage and drop your EIP coverage, you should compare your EIP coverage, including which drugs are covered, with the coverage and cost of any plans offering Medicare prescription drug coverage in your area.

You may have heard that if you decide to enroll in Part D after your initial eligibility period, you will have to pay a higher premium because you did not enroll in Part D when you first had the opportunity. However, because you now have prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later without a penalty. Every year you will have the opportunity to enroll in a Medicare prescription drug plan between November 15 and December 31.

If you drop or lose your coverage with EIP, you have 63 days to enroll in a Medicare drug plan. If you do not enroll in Medicare prescription drug coverage when your coverage ends, you may pay more if you later enroll in Medicare prescription drug coverage. If, after May 15, 2006, or after your initial eligibility date, you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium for Medicare Part D will go up at least one percent a month for every month after May 15, 2006, (or after your initial eligibility date, whichever is later) that you did not have coverage. For example, if you go 19 months without coverage, your premium will always be at least 19 percent higher than the national average Medicare Part D premium. You will have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until the next November to enroll in Medicare prescription drug coverage.

Please keep this notice, your creditable coverage letter, in a safe place. If you later decide to enroll in Part D, you may need to present it to show that you had coverage that was as good as or better than Part D, and therefore, you are not subject to higher premiums.

To learn more about your drug coverage, consult your 2008 *Insurance Benefits Guide* (IBG) or call your health plan or prescription drug plan at the number listed on the inside cover of the IBG.

Your coverage through EIP pays for other health expenses, as well as for prescription drugs. If you enroll in a Medicare prescription drug plan, you will no longer receive the prescription drug benefits offered by your health plan. However, there will be no reduction in your health insurance premium.

For more information about this notice, contact EIP.

You can reach EIP at 803-734-0678 (Greater Columbia area) or 888-260-9430 (toll-free outside the Columbia area).

Note: You may receive copies of this notice again, such as before the next period in which you can enroll in Medicare prescription drug coverage, and if your coverage through EIP changes. You also may request a copy.

For more information about your options under the Medicare prescription drug coverage:

More detailed information about Medicare plans that offer prescription drug coverage is available in the *Medicare & You 2008* handbook, which you got in the mail from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov for personalized help,
- Call your State Health Insurance Assistance Program (see your copy of the *Medicare & You 2008* handbook for the telephone number)
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

Extra help paying for a Medicare prescription drug plan is available to people with limited income and resources. Contact the Social Security Administration (SSA) for more information about this assistance. You may visit SSA online at www.socialsecurity.gov, or call 800-772-1213. TTY users should call 800-325-0778.

Remember: Keep this notice. If you enroll in one of the new Medicare prescription drug plans after your initial enrollment date, you may need to present a copy of this notice when you join to show that you are not required to pay a higher premium.

Contact the Employee Insurance Program below for further information.

Note: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through the Employee Insurance Program changes. You may also request a copy.

South Carolina Budget and Control Board
Employee Insurance Program
1201 Main Street, Suite 300
P.O. Box 11661
Columbia, SC 29211

803-734-0678 (Greater Columbia area)
888-260-9430 (toll-free outside the Columbia area)
cs@eip.sc.gov
www.eip.sc.gov

MEDICARE PART D: FREQUENTLY ASKED QUESTIONS

Q: I received a notice recently about Medicare Part D from the Employee Insurance Program (EIP). What is this?

A: Even though the Medicare prescription drug benefit went into effect on January 1, 2006, EIP will continue to provide you and your covered dependents with your state prescription drug coverage. The notice tells you this coverage is at least as good as the Medicare drug benefit, and it is proof of such coverage. Please keep this notice where you can easily find it.

Q: Do I need to do anything right now?

A: No. There is nothing you need to do if you plan to keep your state coverage through EIP.

Q: What do I need to do if I want to switch to a Medicare plan?

A: If you switch to a Medicare drug plan, you need to enroll within the seven-month initial enrollment period of your Medicare eligibility. More information is available by calling Medicare at 800-MEDICARE (800-633-4227) or at 877-486-2048 (TTY). However, enrolling in a Medicare drug plan will disqualify you from prescription drug coverage under your EIP plan. If you enroll in a Medicare drug plan, you will lose your EIP drug coverage, and there will be no reduction in your health insurance premium.

Q: If I keep my current coverage, can I switch to a Medicare plan later?

A: Yes. After the initial Part D enrollment period, open enrollment for Medicare coverage will be held yearly between November 15 and December 31.

Q: Will I pay higher premiums for a Medicare prescription drug plan if I keep my state coverage through EIP and switch later?

A: No. Since Medicare recognizes your current state coverage through EIP is at least as good as the standard Medicare plan, you will not pay more if you later enroll in a Medicare plan. Remember that you may only enroll in a Medicare prescription drug plan during: 1) open enrollment for Medicare, which is November 15 to December 31 of each year; or 2) if your EIP coverage ends.

Q: Is extra help or limited-income assistance available for prescription drug coverage?

A: Limited-income assistance is not available for your EIP coverage, but it is available for the Medicare benefit. If you think you may qualify, you can apply for assistance by filling out an application online at www.socialsecurity.gov or by calling the Social Security Administration at 800-772-1213 or 800-325-0778 (TTY). Remember: You can only receive limited-income assistance if you enroll in a Medicare prescription drug plan.

Notes

Notes

Total printing costs: $2,716.00
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Contact Information

AETNA
Long Term Care
Long Term Care, RT 32
151 Farmington Avenue
Hartford, CT 06156
Hotline: 800-537-8521
Fax: 860-952-2024
www.aetna.com/group/southcarolina

APS HEALTHCARE INC.
SHP Mental Health and Substance Abuse
Claims, State of SC
P.O. Box 1307
Rockville, MD 20849
Customer Service: 800-221-8699
Tobacco Treatment: 866-784-8454
Fax: 888-897-8931
www.apshealthcare.com
(password=statesc)

BLUECROSS BLUESHIELD OF SOUTH CAROLINA
SHP Standard Plan, Savings Plan, Medicare Supplemental Plan
P.O. Box 100605
Columbia, SC 29260-0605
Customer Service Center:
800-868-2520
803-736-1576
Fax: 803-699-7675

Medi-Call
BlueCross BlueShield of SC
AF 330
I-20 Alpine Road
Columbia, SC 29219
800-925-9724
803-699-3337
Fax: 803-264-0183

BlueCard
800-810-BLUE (2583)

State Dental Plan, Dental Plus
BlueCross BlueShield of SC
P.O. Box 100300
Columbia, SC 29202-3300
Customer Service: 888-214-6230
Fax: 803-264-7739
www.southcarolinablues.com

BLUECHOICE HEALTHPLAN OF SC
P.O. Box 6170
AX-435
Columbia, SC 29260-6170
Member Services:
800-868-2528
803-786-8476
www.bluechoicesc.com

CIGNA HEALTHCARE HMO
P.O. Box 5200
Scranton, PA 18505-5200
Member Services: 800-244-6224
www.cigna.com

EMPLOYEE INSURANCE PROGRAM
Street Address:
1201 Main Street, Suite 300
Columbia, SC 29201
Mailing Address:
P.O. Box 11661
Columbia, SC 29211-1661
Customer Service:
803-734-0678 (Greater Columbia area)
888-260-9430 (toll-free outside Columbia area)
Retiree Billing: 803-734-1696
Fax: 803-737-0825
www.eip.sc.gov

FRINGE BENEFITS MANAGEMENT COMPANY
MoneyPlu$
P.O. Box 1878
Tallahassee, FL 32302-1878
3101 Sessions Road
Tallahassee, FL 32303
Customer Service: 800-342-8017
Automated Information: 800-865-FBMC (3262)
Claims Fax: 888-800-5217
Other Fax: 850-425-6220
www.fbmc-benefits.com

(Continued on inside back cover)

Contact Information *(Continued from front cover)*

THE HARTFORD
Basic Life, Optional Life, Dependent Life
P.O. Box 2999
Hartford, CT 06104-2999
Evidence of Insurability: 800-331-7234
Death Claims: 888-563-1124
Retiree Enrollment /Claims: 888-803-7346, ext. 3648
Conversion: 877-320-0484

MUSC OPTIONS
P.O. Box 6170
AX-435
Columbia, SC 29260-6170
Member Services: 800-821-3023
www.bluechoicesc.com

MEDCO PRESCRIPTION DRUG PROGRAM
SHP, MUSC Options
Claims-Medco Prescriptions
P.O. Box 2277
Lee's Summit, MO 64063-2277
Customer Service: 800-711-3450
www.medco.com

MEDICARE
800-633-4227
877-486-2048 (TTY)
www.medicare.gov

SOUTH CAROLINA RETIREMENT SYSTEMS
P.O. Box 11960
Columbia, SC 29211-1960
Customer Service:
803-737-6800
800-868-9002 (toll-free in SC only)
www.retirement.sc.gov

SOCIAL SECURITY ADMINISTRATION
800-772-1213
800-325-0778 (TTY)
www.ssa.gov
www.socialsecurity.gov

THE STANDARD INSURANCE COMPANY
Basic Long Term Disability, Supplemental Long Term Disability
P.O. Box 2800
Portland, OR 97208
General Information and Claims: 800-628-9696
Fax: 800-437-0961
Medical Evidence: 800-843-7979
www.standard.com

MY HEALTHCARE CONTACTS

Doctors:_____

_____

_____

Dentists:_____

_____

_____

Pharmacies:_____

_____

_____

Hospitals:_____

_____

_____

Other:_____

_____

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South Carolina Budget and Control Board

Employee Insurance Program
P.O. Box 11661
Columbia, SC 29211

803-734-0678 (Greater Columbia area)
888-260-9430 (toll-free outside Columbia area)
Web: www.eip.sc.gov
E-mail: cs@eip.sc.gov